HEALTH SELECT COMMISSION
24th September, 2015

Present:- Councillor Sansome (in the Chair); Councillors Elliot, Fleming, Godfrey, Mallinder, Parker, John Turner and M. Vines, Vicky Farnsworth and Robert Parkin (Rotherham Speakup)

Apologies for absence were received from Councillors Ahmed, Alam, Burton, Hunter, Khan, Price, Rose and Rushforth.

26. DECLARATIONS OF INTEREST

Councillor Fleming made a Declaration of Interest in that he was an employee of Sheffield Hospital Trust. As the Declaration was of a personal (and not prejudicial) nature, Councillor Fleming remained in the meeting and spoke and voted on the items.

27. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no members of the press and public present.

28. COMMUNICATIONS

(1) Yellow Cards
The Chairman reminded Members that they should raise the yellow card if they required clarification on any issue/terminology used.

(2) Joint Health and Overview Scrutiny Committee
It was expected that a meeting would be held in October, 2015, on the issue of Congenital Heart Disease Services

(3) Treeton GP Practice
The Rotherham Clinical Commissioning Group had met with NHS Property Services at the beginning of August and, in conjunction with NHS England, an options appraisal for the Treeton/Waverley site had been submitted to the Primary Care Sub-Committee on 23rd September. Jacqui Tuffnell was to attend the next meeting of the Select Commission and would update on the outcome of the meeting.

(3) RDaSH
The Trust was to hold its third workshop on 25th September at the Unity Centre from 1.30 p.m.-3.30 p.m. to involve local people and partners in plans to transform Adult Mental Health Services across the Borough. RDaSH was particularly interested in hearing from those with direct experience of their Services including family members and carers.

(4) Terri Roche, Director of Public Health
Terri introduced herself to the Select Commission. She had been in post since 29th June, 2015.

Public Health had a statutory responsibility to protect the health of the public and improve the public's health. The Department was organised into 3 domains:-

Health Care Public Health – work to ensure the Health Services worked with health providers to ensure they were the best they could be and ensured they reached the right people in the right ways to address inequalities;
Health Protect – emergency planning – not to deliver the services but to hold other organisations to account and ensure things happened e.g. working with NHSE to make sure Rotherham residents were taking advantage of preventative measures to make sure they lived a long and healthy life
Health Promotion/Education – work in partnership to ensure Rotherham residents had all the information they needed to make healthy choices

29. MINUTES OF MEETING HELD ON 9TH JULY, 2015

Resolved:- That the minutes of the previous meeting of the Health Select Commission held on 9th July, 2015, be agreed as a correct record.

Arising from Minute No. 15(5) (Access to GPs and RDaSH CAMHS Reviews), it was noted that the CAMHS response would be submitted to Commissioner Newsam's 13th October meeting.

Arising from Minute No. 17 (Health and Wellbeing Board – Scrutiny Review of Access to GPs), it was noted that the outstanding part of the response in relation to the recommendations specific for the Health and Wellbeing Board had been discussed and an update would be submitted to the next meeting. Jacqui Tuffnell would be presenting the final Interim GP Strategy to the October Select Commission meeting which would address many of the points raised in the Scrutiny Review particularly GPs and practice workforce issues given the national media coverage regarding the shortage of GPs.

Arising from Minute No. 19 (Hospital Discharges), it was noted that the Quarters 1 and 2 data would be available shortly. Councillor Fleming also raised that he had asked for information relating to pressure ulcers.

Arising from Minute No. 21 (Health and Wellbeing Strategy), it was noted that the Commission had had the opportunity to comment on the draft Strategy. The final version would be submitted to the October Select Commission. It was evident that there was greater emphasis on mental health.

Arising from Minute No. (Provisional Sub-Groups for Quality Accounts), it was noted that the final sub-group memberships had now been confirmed.

30. BETTER CARE FUND

Lynda Bowen, Dominic Blaydon, Kathryn Rawlings and Sarah Whittle gave the following presentations on the Better Care Fund and potential developments from the recent Service review.

Lynda Bowen gave the following overview presentation of the Better Care Fund:-

Better Care Fund Overview
- Plan agreed by NHS England in January, 2015
- Formalised in a Section 75 Partnership Framework Agreement in April, 2015
- Strengthened governance

What does the BCF Plan aim to achieve?
- Better patient/customer experience
- Integrated service provision – seamless services
- More effective provision
- Fewer admissions to permanent care and unplanned emergency hospital admissions
- Shorter lengths of stay in hospital
- Effective reablement

BCF Metrics
- Reduction in non-elective admissions
- Permanent admissions of older people to care homes
- Delayed transfer of care from hospital
- Number of older people at home 91 days after discharge from hospital into rehabilitation

Governance
- Health and Wellbeing Board
- Strategic Vision
- Strategic Executive
- Operational Executive

Current BCF
- Complex Plan
- 72 lines of funding
- 16 workstreams
- 2 pooled funds
- Mixture of new and existing services
- Fragmented data collection
- Fragmented reporting lines
- Potential overlap/gaps in provision

Review of Workstream 13
First review of this workstream showed:-
- Lack of clarity
- Historic grants/funding lines
- Segments of Services funded from other budgets
- Diverse reporting and governance
- Overlap with separate funding areas

Service Review Methodology:-
72 funding streams each reviewed to identify:-
- Strategic relevance
- Areas for merging funding
- Areas for reallocating funding
- Services receiving funding from outside BCF
- Services that required detailed review

Outcomes from the Service Review
- Directory of Services
- Simplified structure for BCF
- Clear measures for metrics
- Revised governance for BCF services
- Recommendations for integrating BCF governance
- Recommendations for future integration and joint commissioning

Key drivers for the new BCF Plan
- Improving services for people of Rotherham
- Complementing transformational change underway in Social Care and with secondary and community health providers
- Integration with Children's Services
- Framed by:-
  Role and requirements of NHS England and Better Care Fund Team
  Ability to impact on metrics and meet performance targets

Discussion ensued on this part of the presentation with the following issues raised and clarified:-

- The 72 lines of funding was a narrative which stated where the Fund would make a difference to the Services that would be funded but there was no project plan as such for each of them. They were aggregated up to a project view for each of the workstreams. It was acknowledged that it was far too complicated but it had served a purpose. The BCF had had to be put together very quickly in the beginning so a pragmatic approach had been taken of what there was, what met the criteria and transferred into a plan

- The way that the metrics were measured was not entirely consistent with the preferred reporting that the CCG used and with CQUINS

- In response to the recent Government announcement in relation to domiciliary care and that providers needed to spend a minimum of at least 30 minutes with service users in their own home, Rotherham's providers did not make 15 minutes calls

- The Strategic Vision Group consisted of Commissioner Manzie, Julie Kitlowski, Chris Edwards, Graeme Betts, Sam Newton, Dominic Blaydon and Linda Bowden. The Group had had its first meeting and discussed ideas which involved the customer perspective and working with providers was an absolute part of the future work. There had been the realisation that the potential in Rotherham was enormous and there was the desire to roll it out. Providers themselves were having discussions about future transformation and had their own ideas about the future. There would be opportunities for other providers to join in that thinking

- There was an awareness that the current BCF did not reflect the whole change agenda and that it had been a pragmatic approach adopted at the time to meet the deadline. Although there was some fantastic work taking place, BCF was not the only change agenda and that was where the Vision Group came in so there was 1 Rotherham vision. There had been a fantastic approach from the voluntary sector who were keen to work with the smaller groups to help them through the change agenda as well as the bigger groups

- There had been no indication of what would happen to the Fund in 2016. It had been the pattern that any information was received at very short notice. Current funding was until the end of 2015 with no guidance on what would happen beyond that date. The services would not stop because there were other ways that could be considered for funding. The Comprehensive Spending Review for the next 3 years was due soon and had previously influenced how the BCF was structured

- Improvement outcomes were measured differently due to the different types of reablement. There was a keenness not to see customers receive reablement early on as a service until they were really in need of it. This was to ascertain how effective the service was at giving the customer confidence, independence and motivation. An ultimate measure was if reablement had kept people at home rather than going back into hospital or into permanent care

- The % of re-admissions to hospital following discharge would be supplied after the meeting
  (TRFT supplied the following data at the end of the meeting:

  - *July – 11.88% patients admitted as an emergency within 28 days of discharge following an emergency admission.*

- *July – 4.6% patients admitted as an emergency within 28 days of discharge following a planned admission)*

- It was not known if the Sheffield City Region would potentially have an effect on BCF. There were some services that overlapped into Sheffield for example the shared Advocacy Services. Discussions did take place with other regions within Yorkshire and the Humber and Sheffield about what they were doing and how they were combining services. What was missing currently were any links to any of the other employment/opportunities that the Sheffield City Region was offering

- Reporting was fragmented due to some projects/services already being in existence prior to BCF; they had their own way of assessing success which did not necessarily correlate with the way the Government BCF outcomes were to be reported as well as some using different reporting routes. Some reported to the Health-led groups e.g. System Resilience Groups, some to the BCF Operations Group and other to the Adults Development Board. It needed to be simple and clear. It was the intention to make a better service for the people in Rotherham and it was known that the patient journey was not always as smooth as it could be. Good work was also taking place outside the BCF

- Children's Services was another area considering moving to an ageless service and it did feel the transition from Children's to Adults was not as smooth as it should be, especially for Mental Health. The integration would be looked at very carefully

- Those Services that had integrated had done so with some success due to working in a slightly different way, talking about where one service stopped and another service started and whether they could be done differently. There were a number of learning points the biggest one of which was talking to Service users, voluntary and community agencies and not one Service trying to do things on their own in silos

- Primary Care was part of the BCF and the Chair of the CCG was herself a GP so there was a very direct link with Primary Care and engagement with the BCF. This was very helpful when looking at the delivery of the Services within the BCF at Primary Care level, talking to GPs, getting Social Workers into GP surgeries, risk strategies in GPs etc.

- There was a Performance for Payment element within BCF. If the targets were not met for non-elective/non-planned admissions it would mean a degree of the funding would be withheld and could not be used to distribute to the projects. However, this did not put projects at risk as there was a Risk Fund - it made no sense at all to plan to fail

- The Care Co-ordination Centre did not need to change as it was doing a good job. There was a separate workstream outside of the BCF which was looking at the customer journey from start to finish to ascertain the best way for those using the Service to get those Services in a simple and clear manner. Like all Services and customer journeys, the Care Co-ordination Centre role and function would be reviewed to check if it could be done in a different way/resourced differently

- Carers, the offer and strategy, and the Carers Emergency Scheme had a renewed focus. It was working well if you knew it was there and that was one of the problems – how did members of the public know they were carers and how to get the help to them. A Carer held a card and attempts were being made to flag that through to GP practices; some practices had a red flag on patient records denoting someone was a carer. There was provision for carers if they had a breakdown in care or needed to go into hospital suddenly/urgent care arrangements and the Scheme would arrange care. There was more money in the budget than was being spent. The infrastructure costs were covered so the Service had stability and as much flexibility as required to deliver the hours that could be provided for carers that had unplanned care needs, however, the message was not getting through to carers

- The Heads of Terms within the Section 75 Partnership Agreement clearly described what both partners, Health and Social Care, had signed up to with regard to mitigation and governance. In terms of mitigation, both parties planned together, delivered together and problem solved together. With regard to mitigation, in terms of future Service delivery, it was anticipated that it would only get stronger and clearer due to the commitment at the highest level and joint working which was starting to show through the specifics in terms of Service plans

At this point Dominic Blaydon, Head of Commissioning for Urgent Care, Rotherham Clinical Commissioning Group, took over the presentation:-

Directory of Services

- Category 1 Mental Health
  Mental Health Liaison Services
  - Dedicated Mental Health expertise provided to A&E 24 hours/day
  - Clinically led and operates from The Woodlands
  - Supports 16-18 year olds overnight and at weekends
  - Works alongside the Crisis Intervention Service
  - Links in with the Emergency Centre Development

- Category 2 Rehabilitation and Reablement
  - Home Improvement Agency
  - Falls and Bone Health Service

- Home Enabling Service
- Community Stroke Team
- Stroke Association – Community Integration
- Community Neuro-Rehabilitation Service
- Rotherham Equipment and Wheelchair Service
- Community Occupational Therapy
- Age UK Hospital Discharge Service
- Good Practice: Integrated Falls and Bone Health
  Targets people over 55 years with fragility fracture
  Multi-factorial Falls Assessment and therapy input
  12 week Falls and Fracture Prevention Programme
  Follow-up exercise programmes commissioned by RCCG
  Patients under 75 years undergo bone density scanning
  Establish fracture probability and prescribe bone active tablets
  Follow up patients at 3 months, 6 months and 1 year
  Check modifiable risk factors and adherence to medication

– Category 3 Intermediate Care
  - Rotherham Intermediate Care Centre
  - Integrated Therapy Team with physiotherapists and OTs
  - 3 residential units with 50 beds
  - Community Rehabilitation Service
  - Day Rehabilitation and Community Integration
  - GP contact for intermediate care
  - Intermediate Care Social Work Service
  - Specialist Mental Health OTs
  - Good Practice: Community Integration
    6 week programme led by Occupational Therapy
    Addresses social isolation and activities of daily living
    Access and utilisation of public transportation
    Development of social networks
    Leisure or recreational activities
    Educational and training activities
    Health and wellness promotion

– Category 4 Protecting Social Care
  - Hospital Social Work Services
  - Supporting Direct Payments and Personal Budgets
  - Residential respite care
  - Supporting people with learning disabilities

– Category 5 Case Management and Integrated Care Planning
  - GP Case Management
  - Integrated Rapid Response Service
  - Care Home Support Service
  - Otago Exercise Programme
  - Death in Place of Choice
  - Good Practice: Integrated Rapid Response

Merge Fast Response Advanced Nurse Practitioners and OOHs
Provides early supported discharge at home
Identifies stable hospital patients who can be supported at home
Respond to patients who are at risk of hospital admission
Co-ordinates care for up to 5 days
Supported by Home Care Enabling Service
Incorporates community rehabilitation

- Category 6 Supporting Carers

Next Steps
- Service review outcomes: options paper to be taken to BCF Executive in October
- Decisions to be taken on strategic priorities for future BCF based on review findings
- Service Integration – greater focus on joint commissioning and Service delivery
- Links with other transformational agendas especially prevention and early intervention
- Build on best practice
- Nominate lead and accountable officers

Discussion ensued on this part of the presentation with the following issues raised/clarified:-

- Although there was no specific slide on carers, the Carers Service transcended many of the Services delivered

- Within BCF there was no funded service for supporting children who cared for adults. However, the new Carers Strategy would be more explicit in the provision for young carers as their needs were somewhat different to the needs of adult carers. There was a desire to separate them out

- There was no link between CQUINS and BCF targets. There was a cost element and they complemented each other but were both developed separately. CQUINS were agreed between the CCG and the provider but were not coterminous with the targets set by NHS England for the BCF. On the whole there was a reasonable compatibility although there was some work still to done. As both BCF and CQUIN were relatively new, it had taken some time for priorities and for the CCG to get them aligned. The Chief Executive of the CCG had been mandated to raise this with NHS England

- The issue of protective clothing in falls prevention and whether it reduced the potential for breakages was being debated as to its effectiveness. In Rotherham protective clothing such as hip protectors would be issued at times. Rotherham's Multi-Factorial Falls Assessment would assess whether protective clothing was

necessary. For those people in the residential care environment the Falls Team would carry out an assessment not just looking at possible interventions but also what types of protection they could recommend to wear. It was not always appropriate e.g. for someone with Dementia but other measures could be introduced and was part of the package they could consider

- The Bone Health Clinic not only administered medication but would identify whether there was an issue and give life choice advice and then prescribe medication. It would be dependent upon whether they felt the patient would comply. It was important that people with a learning disability receive clear information

- Patients would be followed up after 3, 6 and 12 months. It could be by way of a telephone call depending upon the level of risk. If the patient was on bone density medication there would be a follow-up process and it would be a similar process for the Falls Services to ensure the person complied with the rehabilitation programme

- The Intermediate Care Services supported those who were discharged from hospital to ensure Services got the pathway right to stop admissions in the first place

- There was a support process in place in Direct Payment as it was important that customers had control over their care packages. It was hoped to further develop health and social care integration packages which would mean that the customer would have much more control over the services going in. It was not sure how it would apply to those who were Autistic. A lot of work was required to be done within the organisations and awareness around Autism and how their needs were met

- There was an issue for those resident in Rotherham whose GPs were outside the Borough or those that had admissions to a hospital rather than Rotherham District. There was a mechanism in place but it was quite detailed and not specifically related to the BCF

- There had been substantial investment in Hospice Services over the last 3-4 years. There was now an Outreach Service and additional urgent response to enable 24/7 provision for those that were on their end of life pathway. It was essential that the Hospice worked closely with community nursing homes. Although great strides had been made it was really important to ensure that when people reached their end of life they had that choice to make

At this point Kathryn Rawling took over the presentation:-

Alzheimer's Society

What do Alzheimer's Society provide in Rotherham

- Dementia Support Workers offering emotional and practical support

- Memory Cafes
  - Held monthly at Dalton, Maltby Thurcroft and Wath upon Dearne
  - Provided an opportunity to meet regularly and talk about living with dementia in an informal social environment
  - Provided opportunities for people with dementia, families and carers to ask questions of professionals and learn from the experiences of others.
  - A dementia café will provide information about dementia and practical tips about coping with dementia

- Rotherham Unity Centre Memory Café
  - Brings together older people from the BME community including those living with dementia and their carers, from minority ethnic groups, in a relaxed atmosphere where they can meet others in a similar situation to themselves

- Social Outlets
  - Singing for the Brain – held monthly at Lord Hardy Court, Rawmarsh, and Davies Court, Dinnington

- Rotherham Carers Resilience Project
  - A new service working with Crossroads Care, Rotherham, to provide a Dementia Link Worker in all GP practices. The Society provided information and support for carers of people living with dementia in their own homes to build resilience and confidence and prevent and/or manage the risk of carer breakdown. This helped people to continue to live well with dementia in their own homes with the right support for their carers

- Rotherham Dementia Forum
  - Run by Rotherham Alzheimer's Society
  - The Forum brought together people with dementia, their carers and professionals so that they could influence the way services were provided in line with the needs of people with dementia and those who cared for them and also in the development of dementia friendly communities in Rotherham

- CrISP (Carers Information and Support Programme)
  - Aim of the programme was to improve the knowledge, skills and understanding of those caring for people with dementia
  - Programme facilitated peer support and shared learning experience led by training Society staff
  - CrISP included 2 courses:-
    CrISP1 – a 4 session programme aimed at family members and friends who supported a person with a recent diagnosis of

dementia. The modules covered included understanding dementia, legal and money matters, providing support and care and coping day-to-day and next steps
CrISP2 – a 3 session programme covering issues that arose as dementia progressed. The modules covered including understanding change as dementia progressed, live with change as more help was needed and living well as dementia progressed

- National Campaigns
  - Dementia Friends
  - Dementia Friendly Communities
  - Dementia Action Alliance

Discussion ensued on this part of the presentation with the following issues raised/clarified:-

- Dementia was a worldwide problem with someone being diagnosed every 7 seconds. The work of Rotherham Dementia Action Alliance was invaluable by raising awareness of dementia and the Dementia Friends Programme meant that the general public were far more likely to come forward to access services and actually ask for help but it was the tip of the iceberg

- People with dementia became became socially isolated and did not reach out for help. Work done nationally and by the Alliance had the potential of increasing the needs as more people became aware. The more services that were out there prevented people going into crisis

- It was the aim of the Carers Resilience Programme to give people the support to cope and know about the Services available. GPs were being more challenged to increase the diagnosis rate. Some people were proactive and sourced help but 1 of the key symptoms for people exhibiting signs of Alzheimer's was they would not be aware that they were having problems at all and less likely to seek help

- There were approximately over 100 types of dementia which presented in different ways and it was a challenge for the families of people exhibiting and perhaps being in denial. People would go for the simple test at their GP practice and develop good ways of masking the issue. It was good for people to know about the test so they could be encouraged to go to their GP and the work of the Alliance also helped to get that information out into the public arena

- Loneliness was a big issue and if someone attended the services with their partner/family member and they then had a bereavement, the Alzheimer's Society would not prevent the surviving member from attending any more. At the Dementia Cafes attendees formed their own groups and participated in activities socially outside of the Cafes

- The Carers Resilience Alliance, funded by the CCG, was working with the Alzheimer's Society and Crossroads; the more partnership work that took place was for the greater good and could do more working together

At this point Sarah Whittle, Rotherham Clinical Commissioning Group, took over the presentation:-

Social Prescribing

- Connects people with long term conditions referred through case management teams to sources of support in their community aiming to reduce social isolation
- 5 VCS Advisors employed by VAR linked to 36 GP practices work with referred people to find a service or activity that meet their needs
- 26 VCS organisations receive funding to provide a menu of 33 different services and activities
- Provides a gateway to a wider pool of VCS services that are not directly funded through social prescribing, predominantly provided by local community centres and groups

Prescription

- Exercise/healthy lifestyles
- Self-management programmes
- Social and leisure
- Befriending
- Confidence building
- Learning/training
- Money – benefits, debs, fuel poverty
- Housing/adaptations
- Carers support
- Dementia support
- Transportation/mobility
- Advocacy

Why are we doing it?

- Strengthening individuals, strengthening communities
  - NHS Efficiency Challenge – reduces pressure on NHS and Social Care
  - Improves outcomes for patients with long term conditions and their carers
  - Recognition that patients need support with non-medical issues – creates a wider range of options for primary care and patient
  - Shift of focus to prevention and early intervention – increases independence, resilience of individuals and communities
  - Supports integration and personalisation
  - Doing things differently – 'more of the same' is not an option

- Outcomes for Patients and Carers
  - Quantative and qualitative evidence points to a range of improvements for patients and carers
    Improved mental health
    Greater independence
    Reduced isolation and loneliness
    Increased physical activity
    Welfare benefits
  - Social Prescribing represents an important first step to engaging with community based services and wider statutory provision]without Social Prescribing many patients and carers would be unaware of or unable to access these services

- Wellbeing Improvements
  - 83% of patients made progress in at least 1 outcome area
  - 20% reduction in A&E attendances
  - 21% reduction in in-patients stays
  - 21% reduction in out-patients
  - 3,500 patients referred
  - For every £1 spent at least £3 saving
  - The CCG benefits as it addresses inappropriate admissions
  - The GPs benefit as it gives them a third option other from referral to hospital or to prescribed medication
  - The voluntary and community sector benefit as it supports their sustainability
  - The patient and carers love it as it improves quality of life, reduces social isolation and moves the patient from dependence to independence

Discussion ensued on this part of the presentation with the following issues raised/clarified:-

- Although there were pockets of social prescribing across the country, Rotherham was the only place in the country doing it on this scale. The 3rd year operation would be coming out shortly and would be slightly different with a focus on those aged under 80 than those over age of 80 but that did not meant there would be nothing for the latter category

- It had been extended into Mental Health Services where the Mental Health provider was actually referring people into the voluntary sector and hoping to discharge a number of people, who had been under Mental Health Services for a number of years, and give them the help to become more independent and be part of the community. It was currently a pilot in its first year but there were many other areas this model, working with the voluntary sector, could be used and have a choice/need to do things differently in the future

- Quite often a number of the schemes in the voluntary sector were geared towards those who were getting older and female rather than male. The assessor would carry out an independent evaluation of the needs of the client. There were a number of clients who had the beginnings of dementia and been through social prescribing and helped in the community such as having a chat over a cup of coffee. That was for both sexes. There were a number of projects for men as well as women

Resolved:- (1) That the progress made for the Rotherham BCF including more integrated joint working between Health and Social Care and revised and strengthened governance for the BCF be noted.

(2) That the proposed timescale for future developments within the BCF plan be noted.

(3) That the existing good practice arising from the Better Care Fund services in Rotherham be noted.

31. HEALTH AND WELLBEING BOARD

The contents of the minutes of the meeting of the Health and Wellbeing Board held on 8th July, 2015, were noted.

Councillor Roche, Chair of the Health and Wellbeing Board, informed the Commission:-

- BCF – The Board was moving forward and positively commended by the Commissioners in their half yearly report to the Secretary of State.
- Health and Wellbeing Strategy - Final draft would hopefully be approved at the Board meeting on 30th September
- Dame Carol Black had visited Rotherham as part of the National Obesity Service. Even though Rotherham had a higher percentage of overweight people than the norm, Rotherham was seen as a leader for Obesity

The Chairman reported that a number of questions had been received from Select Commission Members who had not been able to attend the meeting. They would be e-mailed to Councillor Roche with the responses submitted to the next meeting.

Arising from Minute No. 5 (Care Act Progress – cap on care costs), it was noted that a number of providers nationally had contacted the Government stating more time was required for planning purposes in regards to the care cap element of the Care Act and this has now been deferred. The cap would have allowed people to have their financial contributions to care managed so that when they reached the care cap (which was set at £72,000) it would then have allowed them access to funding from the local authority.

Local authorities would have been able to start to identify self-funders to enable offers of an assessment to be made and advice/information given. The introduction of the cap in 2016 would have meant these people potentially coming forward to the local authority, so the deferment means there may be unknown potential clients with self-funded care not getting the necessary information and advice they require.

The deferred payment scheme was a loan to be paid back at some stage against their property and the amount of money they could be loaned previously was very limited. Rotherham already had a scheme in place but the new scheme now made this available to everybody.

32. QUARTERLY MEETING NOTES

The notes of the first quarterly meeting with health partners, held on 23rd July, 2015, were noted.

It was noted that the action plan in response to the CQC Children's Safeguarding inspection had been developed and was now on the website as part of the agenda pack for the 30th September Health and Wellbeing Board.

RDaSH had invited the Select Commission to submit input into their CQC submission. The Commission had submitted its CAMHS review report

33. YORKSHIRE AMBULANCE SERVICES - CQC INSPECTION

Janet Spurling, Scrutiny Officer, presented a summary of the outcomes of the CQC Quality Summit for Yorkshire Ambulance Service held on 18th August, 2015. It highlighted that, although there were areas of outstanding practice, there were a number of areas for improvement. The overall rating for the Trust was "requires improvement".

Following a CQC inspection, a Quality Summit was convened to develop an action plan and recommendations based on the findings of the inspection team. A range of stakeholders were invited to the Summit to hear the findings and respond/contribute to the action plan

It had been previously been agreed by the regional Joint Health Overview and Scrutiny Committee that Councillor Rhodes, Wakefield Metropolitan District Council, would attend the Quality Summit on behalf of Health Scrutiny as Wakefield Clinical Commissioning Group were the lead commissioner for the Service. It was proposed that Wakefield Health Overview and Scrutiny Committee would undertake any ongoing monitoring of improvement actions from the CQC inspection report with an invitation to attend such meetings extended to other Health Scrutiny Chairs from the JHOSC.

Resolved:- (1) That the Yorkshire Ambulance Service Quality Account sub-group consider the findings of the inspection and resulting action plans when they scrutinise the Quality Account.

(2) That Wakefield Metropolitan District Council lead on the follow-up work on behalf of the Joint Health Overview and Scrutiny Committee ensuring all JHOSC members are brief and invited to future monitoring meetings.

34. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

35. DATE OF NEXT MEETING

Resolved:- (1) That the planning meeting for the next commission meeting be held on Tuesday, 13th October, 2015, commencing at 3.00 p.m.

(2) That, in light of the Better Care Fund and the current review of the 72 funding streams, a special scoping meeting be arranged to give consideration to the review outcomes and issues that the Select Commission may wish to scrutinise in more depth.